BAPTIST DEKALB HOSPITAL

PATIENT CONSENT FORM

Our Notice of Privacy Policies and Practices provides information about how we may use and disclose Protected Health Information about you. As provided in our Notice, the terms of the Notice may change. If we change our Notice, you may obtain a revised copy by sending a letter to:

Baptist Dekalb Hospital
P.O. Box 640
Smithville, TN 37166
ATTN: Medical Records

You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by the agreement.

By signing this form, you consent to our use and disclosure of Protected Health Information about you for treatment, payment and health care operations. You have the right to revoke this consent at any time by sending notice to the above address. Revocation of consent will not affect disclosures that have already been made.

I, _____, have read the Notice of Privacy Policies and Practices and consent to the disclosure of Protected Health Information for treatment, payment and health care operations.

Signed this _____ day of _____ 2001

_____ _____
Signature of Patient or Representative Relationship to Patient

_____
Hospital Representative